Department of Medical Assistance Services
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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers of EPSDT Private Duty Nursing, EPSDT School Based MCO Carve Out Private Duty Nursing, EPSDT Personal/Attendant Care Services and Managed Care Organizations Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 12/15/2017

SUBJECT: Clarification of Authorization Policies for EPSDT Private Duty Nursing, Personal/Attendant Care and EPSDT School-Based Private Duty Nursing for All Medicaid Fee-for-Service Members

The purpose of this memorandum is to clarify and reiterate several policies related to the service authorization requests for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Private Duty Nursing (PDN), Personal Care and School-Based PDN services for Medicaid Fee-for-Service. Changes communicated in previous memos still apply, including the memo entitled, *Notification of Updates to Certain EPSDT Service Authorization Forms for Fee-for-Service and Managed Care members and Transition of Clinical Reviews of Certain EPSDT Fee-for-Service Authorizations from KEPRO to DMAS Medical Support Unit or DBHDS,* issued on June 30, 2017.

Validation of Medical Necessity

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization is specific to an individual, a provider, a service code, and established quantity of units, and for specific dates of service.

Timeframe for Service Authorization Submissions

As of January 1, 2018, authorization requests for EPSDT Private Duty Nursing and Personal Care services should be submitted at least 10 days, but no more than 30 days prior to the requested service start or renewal date. This is consistent with the KEPRO rules, which accepted submissions of authorization requests for these services no more than 30 days prior to the requested service start or renewal date. The submission of recent clinical information is the best way to ensure that the member's current medical necessity is reflected in the service hours authorized, and to promote continuity with the member's active Plan of Care.

For renewals, the DMAS-7 for EPSDT Personal Care and/or DMAS-62 for Private Duty Nursing should be submitted at least 10 days prior to the expiration date of the current authorization, to avoid potential disruption of services.

Where the member's emergency needs necessitate an authorization request submitted after services have begun, retro authorization will be considered for up to 10 days prior to the acceptance of the **initial** request for services, **or in the case of retroactive Medicaid eligibility**. Payment for any services provided more than 10 days prior to the submission of the initial service authorization request (a brand new request for an individual who has not previously received the service, or who has had the service in the past but has had a break in services; *see Appendix A for more information*) will be forfeited by the service provider. Service providers should familiarize themselves with the policies outlined in the provider manual and previous memos.

Clinician Signatures
The clinician signing the service authorization request and plan of care must do so **no more than 90 days in advance of the requested service start date**. For Private Duty Nursing, this signature must be from a primary care or specialty physician (MD or DO). For Personal Care, the signature may come from a physician (MD or DO, Primary or Specialty Care) or a physician extender (Nurse Practitioner or Physician Assistant). For the purpose of the authorization, the licensed healthcare professional signing these forms *does not* have to be a Virginia Medicaid enrolled provider.

Duration of Service Authorizations
Authorizations for both EPSDT Personal Care and EPSDT Private Duty Nursing services may be approved for durations of 60 days *or longer*, at the discretion of DMAS or its' contractor.

The DMAS-62 includes scales for authorized service hours per day OR maximums for hours per week, to allow enrollees and their caregivers to cover their scheduling needs. Service providers should work with the caregivers, *within the service limits authorized*, to meet their needs and preferences. This includes short-term flexibility for normal events such as breaks from school which may fall during the current authorization period. If an increase in services is desired above the authorized limit and for longer than a two (2) week period, service providers should complete a new authorization request, to include justification for the increased need.

Documentation Requirements for Service Authorizations
The completed DMAS-7 and DMAS-62, and the plans of care (DMAS-7A and CMS 485 or equivalent, respectively) are the primary forms for service authorization requests and therefore must be submitted with **every** authorization or reauthorization request. A **new** request form (DMAS-62 or DMAS-7) must be completed and signed by a healthcare professional within the 30 days prior to **each** request submission. DMAS, therefore, strongly encourages physicians to prioritize appointments with members seeking these service authorizations.

All authorization requests must include supplemental documentation of medical necessity. For new PDN or personal care service requests, this may include but is not limited to discharge summaries and/or the last three (3) physician visit summaries (primary or specialty care). For service reauthorizations/renewals, documentation of the services rendered over a two (2) week

period of care must be submitted. This includes nursing notes for PDN reauthorizations. Personal Care reauthorizations should include personal care attendant notes, task summaries and/or supervisory notes, if available; the DMAS 90 for Agency-directed care, or DMAS 99 for Consumer-directed care, or equivalent, will be accepted.

Service authorization requests that do not include all the documentation listed above will be considered incomplete and rejected. If a service authorization is rejected because it is incomplete, providers will need to submit a **new** service authorization request. Dates of authorization will begin based on the date of submission of the new **complete** request.

Reimbursement Rates
There is no change in reimbursement rates.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated

Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html